

DBVI-70-085 DEPARTMENT FOR THE BLIND AND VISION IMPAIRED
DB 3/04 CONSENT TO RELEASE INFORMATION

Authorization Form

Authorization for Use or Disclosure of Protected Health Information

I authorize:

(name and address):

To use and/or disclose the following Protected Health Information to:

(name and address):

This protected health information is being used or disclosed for the following purposes:

Description of Protected Health Information to be released: **(be specific in your request – check the items requested)**

- | | | |
|--|---|--|
| <input type="checkbox"/> Vocational | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Psychiatric Records |
| <input type="checkbox"/> DME | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Psychological Records |
| <input type="checkbox"/> Laboratory | <input type="checkbox"/> Contact Notes | (excludes psychotherapy notes) |
| <input type="checkbox"/> Medical Diag. | <input type="checkbox"/> Progress Note | <input type="checkbox"/> Educational |
| <input type="checkbox"/> Radiology | <input type="checkbox"/> Consultations | <input type="checkbox"/> Criminal |
| <input type="checkbox"/> Films | <input type="checkbox"/> Discharge Reports | <input type="checkbox"/> Employment |
| <input type="checkbox"/> Reports | <input type="checkbox"/> Physician Orders | |

Other records (specifically describe below)

This authorization shall be in force and in effect until _____ or if “none,” specified, no later than one year from the date of signature at which time this authorization expires. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Contact at **8004 Franklin Farms Drive, Richmond, VA 23288 or HIPAAPRIVACY@drs.state.va.us**. I understand that a revocation is not effective to the extent that my provider has relied on it. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the HIPAA Privacy Rule. My provider will not condition my treatment on the provision of this authorization. DSA services may be compromised without the necessary protected health information being disclosed to determine service feasibility

Consumer PRINTED Name:

SSN#

Consumer DOB

Signature of Consumer or Personal Representative

Date

Print Name of Personal Representative (if applicable):

Description of Personal Representative's Authority:

[Provide a copy of this form to the consumer.]

Procedures for the Consent to Release Information Form (REV. 10/03)

The agency initiates the completion of the "Consent to Release Information" form with the individual. The agency may use the form to request or to transmit information to other entities. A separate form needs to be completed for each entity.

WHEN PROPERLY EXECUTED, THIS IS A LEGALLY VALID DOCUMENT FOR EXCHANGING CLIENT INFORMATION. The Consent to Release Information form has been reviewed by the Office of the Attorney General to assure compliance with federal and state confidentiality requirements including HIPAA.

To ensure compliance with federal alcohol and drug abuse confidentiality requirements, this form excludes the general sharing of information about clients in drug and alcohol programs. A separate release of information form specifically for alcohol and drug abuse records should be used each time information is shared between agencies (**DBVI 70-092**).

Instructions for Completing the Consent to Release Information Form

- The *Consent to Release Information* form is designed for use along with the agency's specific procedures for obtaining a valid release to release/exchange information.
- Agency staff and the consumer will determine what entities or agencies information will need to be obtained from or shared with. This determination should be based upon the needs, interests and circumstances of the consumer as well as staff's knowledge of other agencies' or entities services that may benefit the consumer
- Staff should make every attempt to ensure that the consumer or consenting person understands the provisions of the form and should make appropriate efforts to accommodate the special needs of the same.
- If the person(s) is unable to read or is blind or visually impaired, staff should read the form. Interpreters should be made available for people who do not speak English and for those who are deaf or hearing impaired. If the person(s) does not appear to comprehend the meaning of the form, it should be explained.

NOTE: If staff have ANY doubts that the consenting person does not comprehend the purpose and provisions of the form, they should ask the consenting person(s) questions about the form (what the form allows the agency to do and what the various provisions mean). Based upon these answers, if staff determines that the consenting person does NOT comprehend the purpose and provisions of the form, staff should follow their agency's procedures for assuring that the form is signed by a legally authorized consenting person who fully comprehends the purpose and provisions of the form. **THE SIGNATURE OF A CONSENTING PERSON WHO DOES NOT COMPREHEND WHAT HE OR SHE IS SIGNING IS NOT VALID.**

The form should be completed with the information as follows:

- Complete the **"I Authorize"** section with information that includes:
 - The name of the entity that we are requesting the information from.
 - Address of the entity that we are requesting information from
- Complete the **"To use and/or disclose"** section with information that includes:
 - The agency name (Department for the Blind and Vision Impaired)
 - The requestors name and position followed by (or successor)
 - The address of the agency requesting information.
- Identify why the information is being requested (i.e., case coordination, eligibility, etc.)

- Check the box next to the information that is being requested. If the pre-selected choices don't meet your needs, specifically identify the information that you are requesting in the space provided for "other records".

NOTE: A client may want to exchange most but not ALL of the specific information checked (e.g., a reference to past psychiatric hospitalization contained in psychiatric records). If the client wants some specific parts of a record to remain confidential, the agency **MUST** exclude this information when that record is shared.

- Insert an agreed upon date or condition upon which the consent will expire; note that "until case closure" is not acceptable;
- Print the client's name, date of birth and social security number (SSN).
NOTE: Section 2.1-385 of the Code of Virginia, as amended, makes it unlawful to REQUIRE a person's Social Security number in order to obtain benefits or services unless a specific law allows the agency to require it;
- The consumer or consenting person(s) must sign the form and insert the date in the indicated place.
- If signed by a representative then identify the relationship authority.

FOR SPECIAL EDUCATION RECORDS: Confidentiality regulations governing special education records require the signature of a parent for release of records, even when the child is between the ages of 18 to 22. The same regulations do not prohibit obtaining the child's signature in addition to the parent's signature. In cases in which special education records are included in information consented to be released, obtaining both the parent's and the child's signatures will permit the intended exchange of information among those other agencies which require the signature of a person over 18 for release of personal information.

- For those agencies with procedures requiring a witness (e.g., for a person who cannot write), space is provided for a witness to sign the form. The witness must observe the consenting person(s) sign or place a mark on the form and then must sign as indicated.
- The referring agency must give a copy of the completed form to the consenting person(s).

To share information between other agencies within the Disability Services Agencies (DSAs) no authorization is needed. The agencies that are included in the DSAs are:

DBVI – Department for the Blind and Vision Impaired
DDHH – Department for the Deaf and Hard of Hearing
DDS – Disability Determination Services
DRS – Department of Rehabilitative Services
VBPD – Virginia Board for People with Disabilities
WWRC – Woodrow Wilson Rehabilitation Center

Privacy Protection Act Requirements

To ensure compliance with the requirements of the Privacy Protection Act, EACH time information is disclosed by ANY of the listed agencies, staff of the DISCLOSING AGENCY must enter the following information into the client's record:

- Name of the agency and the name, title, telephone number of individual receiving the information;
- Type of source of the information disclosed;
- Reason or purpose for the disclosure; and
- Date the information was disclosed.

This requirement can be met by using a disclosure log or through the agency's own record keeping policies and procedures.

NOTE: The consenting person(s) has the right to review the records of disclosure of the referring and other agencies upon request during the agencies' business hours.

Agency Record Keeping Policies and Procedures

The original signed copy of the *Consent to Release* Information form, disclosure record and any related materials shall be maintained in accordance with the agency's record keeping policies and procedures.

Revocation of Consent

Consent to release information will expire on the date agreed or one year if no date is specified.. However, anytime prior to the expiration, the consenting person(s) may choose to revoke or cancel this consent.

The consenting person(s) may revoke his or her consent by informing the Privacy Contact as identified on the form at the address or email address reflected on the form; the revocation must be in writing

This notification will be noted on the back of the *Consent to Release* Information form, and the privacy official receiving this notice shall inform all other DSA agencies of the revocation by email.